

Minutes



National Diabetes Leadership Group – Implementing Living Well with Diabetes

Date: Thursday 15 November 2018

Time: 09:30am – 3:30pm

Location: Room 2S5, Ministry of Health, 133 Molesworth Street, Wellington

Chair: Paul Drury

Attendees: Bryan Betty, Sian Burgess, Wing Cheuk Chan, Deb Connor, Laila Cooper, Charlotte Harris, Jeremy Krebs, Catherine Lofthouse, Sue Riddle, Ariana Roberts, Andrea Rooderkerk,

Michele Garrett(VC 2.00pm), Catherine Gerard (11.00-11.20), Brenda Hynes and David St George(1.15pm)

Apologies: Nicola Ehau

Item	Notes
1	<p>Welcome and conflicts of interest register:</p> <p>Paul welcomed the group.</p> <p>Welcomed Ariana Roberts representing DHB GM group attending in place of Nicola Ehau.</p> <p>Paul stated the importance of ensuring that Māori are represented at each meeting. Noted that the TOR do not usually allow replacement group members.</p> <p>There were no new conflicts of interest advised.</p>
2	<p>Review of minutes and action points from previous meeting</p> <p>Minutes from the previous meeting 31 July 2018 v2 were discussed and accepted following an amendment stating that (Ministry of Health staff present do not wish to be involved in this process -addendum post meeting)</p>

The following action items were discussed and noted:

	Item	Action	Discussion/update	New Action
1	2016/35	Discuss new technology for Type 1	Importance that apps and devices are validated. The group advised that clinically the devices make an enormous difference. Bryan advised the group that PHARMAC has received an application to the Diabetes subcommittee.	CLOSED 15 Nov 2018 Diabetes NZ and Bryan to keep on the PHARMAC agenda and update the group
2	2017/04	Ask Tofa and Sera if they are interested in supporting NDLG	Māori representation essential. Pacifica representation discussed – concerns re demand and pressure on Pacifica to provide representation.	Jeremy to ask Dr.Riz Firestone If she is willing to be part of the group. She has public health and Pacifica expertise NDLG to suggest any other potential candidates by end Nov 2018
3	2017/11	Inpatients - Standardise care in hospital Agenda item for DHB visits	Nursing study day inpatient symposium morning of NZSSD conference proposed (7-10 May) South island alliance developing modules	Ongoing Jeremy to talk with Rosemary Hall about presenting at NZSSD
4	2017/13 2017/20	Lab Test data	Presentation by MOH IT team on agenda (15Nov)	Ongoing
5	2017/14	Early onset type 2	Concern that severity is not recognised in primary care BPAC published <i>A rising tide of type 2 diabetes in younger people: what can primary care do?</i>	Copy of BPAC to be sent to all clinical leads in all DHBs and to NDLG
6	2017/18	Fran or Craig update on		Invitation to present at

		children and young people		April 2019 NDLG meeting
7	2017/21	Diabetes resources	Discussion on central repository of diabetes resources best managed by Diabetes NZ	CLOSED 15 Nov 2018
8	2018/07	CVD consensus statement	Discussion and concerns of group noted.	Ongoing
9	2018/08	Type 1 recommendations from Allen and Clarke work	Send evaluation reports to group- completed	CLOSED 15 Nov 2018
10	2018/09	Type 1 recommendations from Allen and Clarke work	Group recommended an introductory cover page noting the context in which the report is carried out and the limitations identified to ensure the findings are not misinterpreted is added to letter to paed/young adult services re analysis of support needs	Sian and Catherine to set up meeting with Bryan and Deb to support progress
11	2018/10	Self-assessments against quality standards	Send all DHB a response-completed	CLOSED 15 Nov 2018
12	2018/11	Aged Residential Care (ARC) services	Prepare an executive summary on ARC services	Sian and Catherine to follow up with Andrea
13	2018/12	NDLG TOR	Share with group- completed	CLOSED 15 Nov 2018
14	2018/13	NDLG items for discussion next meeting	Agenda item 15 Nov 2018	CLOSED 15 Nov 2018
15	2018/14	Pre diabetes paper	Wing has received favourable peer reviews and is in process of new iteration and publication	CLOSED 15 Nov 2018
16	2018/15	NDLG areas of focus post LWWD	Agenda item 15 Nov 2018	Ongoing

3	<p>Ministry and group update</p> <p>Sue provided an overview of government direction, health system, ministry priorities and update on CVDRAM.</p> <p>Government has an ambitious agenda for health- focus on vulnerable children, equity and social wellbeing.</p> <p>Health and disability review includes primary care- intergenerational review led by Heather Simpson</p> <p>Mental health and addictions review in progress</p> <p>DHBs and MOH fiscally very constrained</p> <p>Sue provided an overview of CVDRAM. Group discussion around issues;</p> <p>2 years sector engagement and development. The 2 year duration mainly related to the delay to the availability CVD risk algorithm rather than 2 year worth of active work and engagement.</p> <p>Universal support from the sector to have a formal guideline process to cover a number of clinical and implementation issues. Consensus statement process had limited scope and focussed on the risk algorithm without considering the clinical workflow, and how sector responded to the recommendations. Many groups that had provided feedback was ignored (e.g. gout) Paul noted that micro-vascular complications (such as eye and kidney complications) related to diabetes were excluded from scope of the CVD consensus statement very early on in the process.</p> <p>The consensus process had very limited opportunities to actively discuss many of the technical issues, and Charlotte noted many of the technical issues that were discussed in the diabetes leadership group are often not visible to primary health care.</p> <p>MOH published consensus statement Jan 2018, Lancet articles May 2018. Implementation issues have not been adequately addressed by the consensus statements in terms of packaging a range of associated risk factors to support clinical workflow, improve patient's experience. There was no recommendation on how to address amenable risk factors of younger persons who have short term CVD risk that would often require continual support for behavioural change. The information captured as part of initial CVD risk assessment can be actively used as clinical actionable alerts for clinicians for provide the ongoing support and followup required to modify amendable risk factors. .</p> <p>Wing expressed concerns that current CVDRAM will increase inequities, delay in population health gain, as the treatment threshold (that is interpreted by the sector) would be highly inconsistent with international guidelines. Shared decision making can be misinterpreted as clinical action is discretionary, resulting in population groups with poor health literacy not getting the indicated treatment consistent with treatment threshold. Shared decision should be always part of the clinical decision regardless of CVD risk.</p>

	<p>The treatment threshold recommended by the consensus statement is not consistent with the clinical threshold elsewhere with cardiovascular disease, e.g. a population group (e.g >75 year olds who would be offered highly costly invasive coronary interventions by default but primary prevention (which are highly cost effective) and risk assessment (for >75 year old) prior to the event would only be discretionary.</p> <p>Some of group would like to see the clinical recommendations rephrased, with active recommendations to better support clinical workflow and patient's experience. . There is a lost opportunity to intervene with younger groups with modifiable risk factors. Some helpful guidance or standards can be helpful to limit clinical variations.</p> <p>The clinical guidance needs to be refined first before the IT tool is to be designed and implementation. Ministry needs to take a firm lead to provide national IT support for CVD risk assessment and management.</p> <p>Jeremy would like to see more centralisation and all DHBs to use the same IT system</p> <p>Charlotte asked if the IT vendors had been consulted yet- vendors already creating their version of the tool- but validation is required (is this from Heart Foundation or MoH?) Centralisation co-ordination is best practice to avoid fragmentation across the country- which in turn may produce post-code inequities. Also requested communication to the sector on an ETA or progress is advisable. The PMS dashboards (again different vendors but can be PHO led) have prompts for screening which can be implemented now, but the actual RA tool needs to be embedded to then decide on correct management) (Two different enablers.)</p> <p>Action: MoH to consider to next steps in regard to the content and implementation of the CVD consensus statement.</p>
4	<p>HQSC Diabetes Atlas of Variation</p> <p>Catherine Gerard presented the latest update of the Atlas, which allows for more in-depth analyses. PHO analyses will be sent directly to PHOs.</p> <p>Wing noted that the robustness of the indicators would be substantially be improved if lab results are available to be analysed. Furthermore, if lab results are available, the indicators would be more definitive in defining the next improvement steps, rather than displaying the clinical variations.</p> <p>The group were supportive and a further discussion on dementia data.</p>
5	<p>ADA and EASD guidelines</p> <p>Paul gave an overview of the development of the joint guidelines. 2015 was an update of 2012 guidelines.</p> <p>2018 didactic recommendations, previously much more constrained regarding new agents. Now there are a plethora of studies supporting SGLT2 inhibitor or a GLP-1 receptor agonist for clinical CVD. Jeremy noted some of the new medications are important ("game changer") as they have been shown to improve CVD outcomes (for people with diabetes with high CVD risks).</p>

	<p>Discussion. Bryan update from PHARMAC- lots of work going on defining cost implications, huge degree of complexity. PHARMAC wanting to ensure equity, no doubt of qualitative gains but there is a need to ensure affordability by narrowing the group who can benefit the most. Risk of increasing inequity, physicians already advising people to pay for medications. Māori and Pacifica more likely to have co morbidities and less likely to have insurance coverage</p> <p>NZSSD can add supporting opinion on the role of new medications in the NZ context. Special authority can't include age, ethnicity or Dep (CSC users).</p> <p>For Māori living in high Dep equals less pharmaceuticals. Role for the kaiāwhina workforce to support improved understanding, effective where there is good supervision.</p> <p>Primary care referrals to Diabetes NZ are constrained by privacy and consent.</p> <p>GP workforce is changing - power of consumer advocacy and access to medications.</p> <p>Action: Bryan to continue to provide PHARMAC updates to the group</p>
6	<p>Data and Digital</p> <p>Brenda Hynes gave a ppt presentation on the vision for technology for the health and disability sector. Current system is fragmented and unsustainable, the digital health strategy focuses on how services will be delivered to be successful. It is about to be signed off and will be available on MOH website.</p> <p>Electronic health record is now called National Health Information Platform.</p> <p>Wing voiced concerns that the Qlik sense was not necessarily going to address many of the underlying issues of poor data capture, inconsistent data standards, and support clinical actions for front line staff. There are a number of additional requirements will be needed to ensure access to a national lab data repository that support clinical actions in the front line.</p> <p>David St George concluded with an overview of Qlik Sense the Ministry's new analytics tool. Sue noted that a data display tool such as Qlik sense does have some functional limitations from her experience in Stats NZ.</p>
7	<p>Optimizing Foot Screening, Referral Pathways and Protection Services</p> <p>Michele Garrett gave an overview. Discussion included socialisation of the diabetic foot risk screening tool. Advance forms and pathways that may be different by DHB/PHO.</p> <p>Plea to make Podiatry risk screen a compulsory component of the DAR.</p> <p>Issues</p> <p>Information flow between podiatry and GPs and people falling through the gaps</p> <p>Sharing data</p> <p>Ending avoidable LLA within a generation</p> <p>Training in foot screening by allied health and others</p>

	Footwear lifestyle messaging about protecting the foot Continuation of the foot group Action: Ministry to follow up with Michele	
8	The group's clinical actions/concerns Potential areas of focus post-LWWD	
	Name	Priorities
	Wing	CVD consensus statement IT systems to support clinical workflow including data capture of clinical relevant elements Ways to support the primary health care to meet ever increasing demand
	Laila	Gum disease added to Quality standards NZ oral health network Perioperative glycemic control Lack of funding- doing the same with less
	Charlotte	Multi layers- high numbers of referrals, retinal, podiatry etc- high number of DNA's Investigate a one stop shop- Seamless for patients No IT enabler
	Deb	Coordination of care Access to allied health Podiatry, dietitian, retinal
	Jeremy	Decrease primary care workload Cost effective organised DSME- increase health literacy Centralise provision of DSME and peer support Inpatients: interface between hospital at discharge
	Ariana	DSMES IT systems development Pharmacy

		Referral system
	Bryan	Integration Bring everything in house Package of care Dietitians at GP practice
	Andrea	Focus on youth 15-24 – psychological support and transitioning How to better support PHO to deliver ongoing DSME across the lifespan- NZQA qualification?? Facilitators, learners, peers supporters
	<p>Brief discussion on Green Prescriptions</p> <p>Recommended minimum data elements to be captured as part of contraction to enable better evaluation.</p> <ol style="list-style-type: none"> 1. NHI, 2. before, and after height and weight, 3. consent participants to link MOH data/ lab results <p>Additional lab tests such as HbA1c do not need to be requested as part of the program, and consent to data linkage would allow access of HbA1c results that are routinely carried out by primary health care.</p> <p>Expected standards (of contents) of green prescriptions.</p> <p>Improve links with HPA</p> <p>Action: NDLG to think about areas of focus for post LWWD – share ideas by end Jan 2019</p> <p>Paul noted that Living Well with Diabetes comes to an end June 2020.</p>	
9	<p>Next meeting</p> <p>9 April 2019</p>	